

		FOR OFF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0042416</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>PLEASANT VIEW</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01-01-02</u> to <u>12-31-02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>500 NORTH JACKSON</u> <u>MORRISON</u> <u>61270</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>WHITESIDE</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>815 772-7288</u> Fax # <u>815 772-2399</u>		(Type or Print Name) <u>ALAN GAPINSKI</u>	
IDPA ID Number: <u>362819435003</u>		(Title) <u>PRESIDENT</u>	
Date of Initial License for Current Owners: <u>12-06-1996</u>		(Signed) _____ (Date) _____	
Type of Ownership:		(Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) _____	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>()</u> Fax # <u>()</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001	
In the event there are further questions about this report, please contact: Name: <u>ALAN GAPINSKI</u> Telephone Number: <u>815 778-3683</u>		Phone # (217) 782-1630	

STATE OF ILLINOIS

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Facility Name & ID Number PLEASANT VIEW# 0042416 Report Period Beginning: 01-01-02 Ending: 12-31-02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 74

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>74</u>	Intermediate (ICF)	<u>74</u>	<u>27,010</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,010</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>17,003</u>	<u>8,183</u>		<u>25,186</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,003</u>	<u>8,183</u>		<u>25,186</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.25%

D. How many bed-hold days during this year were paid by Public Aid?

63 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)F. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location

Date started 12/6/1996

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/6/1996 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAU ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	161,993	16,330	6,178	184,501	568	185,069		185,069		1
2	Food Purchase		133,595		133,595		133,595	(3,330)	130,265		2
3	Housekeeping	36,707	11,683		48,390	155	48,545		48,545		3
4	Laundry	43,052	11,483		54,535	155	54,690		54,690		4
5	Heat and Other Utilities			60,294	60,294		60,294	(2,966)	57,328		5
6	Maintenance	59,021	18,907	15,341	93,269	180	93,449		93,449		6
7	Other (specify):*										7
8	TOTAL General Services	300,773	191,998	81,813	574,584	1,058	575,642	(6,296)	569,346		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	795,458	58,201	1,680	855,339	(21,648)	833,691	(15,933)	817,758		10
10a	Therapy	23,037		2,333	25,370		25,370		25,370		10a
11	Activities	53,055	4,942	960	58,957		58,957		58,957		11
12	Social Services	53,631			53,631		53,631		53,631		12
13	Nurse Aide Training			5,335	5,335	18,533	23,868		23,868		13
14	Program Transportation		2,459		2,459	(984)	1,475		1,475		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	925,181	65,602	13,308	1,004,091	(4,099)	999,992	(15,933)	984,059		16
	C. General Administration										
17	Administrative			117,194	117,194		117,194	(11,730)	105,464		17
18	Directors Fees										18
19	Professional Services			12,166	12,166		12,166	4,930	17,096		19
20	Dues, Fees, Subscriptions & Promotion			18,858	18,858		18,858	(10,800)	8,058		20
21	Clerical & General Office Expense	39,780	8,633	12,306	60,719		60,719	755	61,474		21
22	Employee Benefits & Payroll Tax			194,615	194,615	(2,425)	192,190	10,183	202,373		22
23	Inservice Training & Education			807	807		807		807		23
24	Travel and Seminar			5,460	5,460		5,460	153	5,613		24
25	Other Admin. Staff Transportation							463	463		25
26	Insurance-Prop.Liab.Malpractice			37,340	37,340		37,340	303	37,643		26
27	Other (specify):* SALES TAX				636		636	(636)			27
28	TOTAL General Administration	39,780	8,633	398,746	447,795	(2,425)	445,370	(6,379)	438,991		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,265,734	266,233	493,867	2,026,470	(5,466)	2,021,004	(28,608)	1,992,396		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PLEASANT VIEW

#0042416

Report Period Beginning:

01-01-02

Ending:

12-31-02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			44,275	44,275	(180)	44,095	66,781	110,876			30
31	Amortization of Pre-Op. & Org											31
32	Interest			27,244	27,244		27,244	91,663	118,907			32
33	Real Estate Taxes			30,438	30,438		30,438		30,438			33
34	Rent-Facility & Grounds			155,698	155,698		155,698	(155,698)				34
35	Rent-Equipment & Vehicle			6,000	6,000		6,000		6,000			35
36	Other (specify): ^a GOODWILL			11,316	11,316		11,316	(11,316)				36
37	TOTAL Ownership			274,971	274,971	(180)	274,791	(8,570)	266,221			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					984	984		984			38
39	Ancillary Service Center:					4,662	4,662		4,662			39
40	Barber and Beauty Shops	7,514			7,514		7,514		7,514			40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify): ^a											43
44	TOTAL Special Cost Centers	7,514		40,515	48,029	5,646	53,675		53,675			44
45	GRAND TOTAL COST											
	(sum of lines 29, 37 & 44)	1,273,248	266,233	809,353	2,349,470		2,349,470	(37,178)	2,312,292			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Program				3
4 Non-Patient Meals	(3,330)	2		4
5 Telephone, TV & Radio in Resident Room	(2,966)	5		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patient				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	13,034	30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refund				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(636)	27		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transaction				15
16 Personal Expenses (Including Transportation				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainer				22
23 Malpractice Insurance for Individual				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotiona	(11,107)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employee				27
28 Yellow Page Advertising	(494)	21		28
29 Other-Attach Schedule	(28,058)	6,21,10		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,557)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule	\$		31
32 Donated Goods-Attach Schedule			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(3,621)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (3,621)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (37,178)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport	X		\$ (984)	14,38	38
39					39
40 Gift and Coffee Shop					40
41 Barber and Beauty Shop					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$ (984)		47

PLEASANT VIEW

ID# 0042416

Report Period Beginning: 01-01-02

Ending: 12-31-02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	GOODWILL	\$ (11,316)	36	1
2	FLOWERS	(809)	21	2
3	EMPLOYEES @ OTHER FACILITIES	(15,933)	10	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(28,058)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PLEASANT VIEW

0042416

Report Period Beginning:

01-01-02

Ending:

12-31-02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,330)	0	0	0	0	0	0	0	0	0	0	(3,330)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,966)	0	0	0	0	0	0	0	0	0	0	(2,966)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,296)	0	0	0	0	0	0	0	0	0	0	(6,296)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(15,933)	0	0	0	0	0	0	0	0	0	0	(15,933)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(15,933)	0	0	0	0	0	0	0	0	0	0	(15,933)	16
	C. General Administration													
17	Administrative	0	11,651	48,060	57,404	(128,845)	0	0	0	0	0	0	(11,730)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	3,652	1,278	0	0	0	0	0	0	0	4,930	19
20	Fees, Subscriptions & Promotions	(11,107)	0	307	0	0	0	0	0	0	0	0	(10,800)	20
21	Clerical & General Office Expenses	(1,303)	0	2,058	0	0	0	0	0	0	0	0	755	21
22	Employee Benefits & Payroll Taxes	0	0	961	9,222	0	0	0	0	0	0	0	10,183	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	153	0	0	0	0	0	0	0	0	153	24
25	Other Admin. Staff Transportation	0	0	463	0	0	0	0	0	0	0	0	463	25
26	Insurance-Prop.Liab.Malpractice	0	0	303	0	0	0	0	0	0	0	0	303	26
27	Other (specify):* SALES TAX	(636)	0	0	0	0	0	0	0	0	0	0	(636)	27
28	TOTAL General Administration	(13,046)	11,651	55,957	67,904	(128,845)	0	0	0	0	0	0	(6,379)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(35,275)	11,651	55,957	67,904	(128,845)	0	0	0	0	0	0	(28,608)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	13,034	51,249	1,752	746	0	0	0	0	0	0	0	66,781
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0
32	Interest	0	89,177	422	2,064	0	0	0	0	0	0	0	91,663
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0
34	Rent-Facility & Grounds	0	(155,698)	0	0	0	0	0	0	0	0	0	(155,698)
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
36	Other (specify):* GOODWILL	(11,316)	0	0	0	0	0	0	0	0	0	0	(11,316)
37	TOTAL Ownership	1,718	(15,272)	2,174	2,810	0	0	0	0	0	0	0	(8,570)
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(33,557)	(3,621)	58,131	70,714	(128,845)	0	0	0	0	0	0	(37,178)

Facility Name & ID Number PLEASANT VIEW

0042416

Report Period Beginning: 01-01-02 Ending: 12-31-02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BIG MEADOWS, INC.	100.00%	BIG MEADOWS, INC.	SAVANNA			
AMERICAN HEALTH ENTERPRISES	100.00%					
ALAN GAPINSKI	100.00%					
	0.00%	WINNING WHEELS, INC.	PROPHETSTOWN			
	0.00%	STRIVE	PROPHETSTOWN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 155,698	OSO PARTNERS - OWNERS OF BUILDING	100.00%	\$	(155,698)	1
2	V	30	DEPRECIATION				\$ 51,249	51,249	2
3	V	32	MORTGAGE INTEREST				\$ 89,177	89,177	3
4	V	17	PROFESSIONAL SERVICES	117,194	AMERICAN HEALTH ENTERPRISES, INC.	100.00%	\$ 128,845	11,651	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 272,892			\$ 269,271	\$ * (3,621)	14

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-02 Ending: 12-31-02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AMERICAN HEALTH ENTERPRISES, INC.								\$		1
2			DIRECT								2
3	ALAN GAPINSKI	PRESIDENT	MANAGEMENT	100.00							3
4											4
5	BIG MEADOWS, INC.			100.00	32,100	14	28.00	MANAGEMENT	136,012	N/A	5
6	PLEASANT VIEW			100.00	22,930	10	20.00	FEES	117,194	17,3	6
7	WINNING WHEELS, INC.			0.00	41,275	18	36.00		207,250	N/A	7
8	S.T.R.I.V.E.			0.00	11,465	5	10.00		105,250	N/A	8
9	OTHER (NON-COST REPORTING)			0.00	6,875	3	6.00		114,500	N/A	9
10											10
11											11
12											12
13								TOTAL	\$ 680,206		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number PLEASANT VIEW# 0042416

Report Period Beginning:

01-01-02Ending: 12-31-02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization AMERICAN HEALTH ENTERPRISES, INC
 Street Address 501 6TH AVE. WEST
 City / State / Zip Code LYNDON, IL. 61261
 Phone Number (815-778-3683
 Fax Number (815-778-4503

B. Show the allocation of costs below. If necessary, please attach worksheets

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DIRECT COST	1	1	\$ 48,060	\$ 48,060	1	48,060	1
2	17	ADMINISTRATIVE	GROSS REVENUE	11,468,000	5	278,001	278,001	2,368,000	57,404	2
3	22	BENEFITS	DIRECT COST	1	1	961		1	961	3
4	22	BENEFITS	%SALARY	527,291	5	46,165		105,328	9,222	4
5	19	DATA PROCESSING	GROSS REVENUE	11,468,000	5	17,687		2,368,000	3,652	5
6	20	DUES,FEES,SUBSCRIPTIONS	GROSS REVENUE	11,468,000	5	1,485		2,368,000	307	6
7	21	SUPPLIES,PHONE	GROSS REVENUE	11,468,000	5	9,965		2,368,000	2,058	7
8	19	ACCOUNTING	GROSS REVENUE	2	2	2,555		1	1,278	8
9	24	TRAINING,SEMINARS	GROSS REVENUE	11,468,000	5	739		2,368,000	153	9
10	26	INSURANCE	GROSS REVENUE	11,468,000	5	1,466		2,368,000	303	10
11										11
12	25	ADMIN. TRANSPORTATION	GROSS REVENUE	11,468,000	5	2,240		2,368,000	463	12
13	30	DEPR'N VEHICLES	GROSS REVENUE	11,468,000	5	8,487		2,368,000	1,752	13
14	30	DEPR'N EQUIPMENT	GROSS REVENUE	11,468,000	5	3,611		2,368,000	746	14
15	32	INTEREST VEHICLES	GROSS REVENUE	11,468,000	5	2,046		2,368,000	422	15
16	32	INTEREST (WORKING CAP)	DIRECT COST	2	2	4,128		1	2,064	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 427,596	\$ 326,061		\$ 128,845	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	MORTGAGE SEE SCH VII B		X	MORTGAGE	\$11,591.00	12/1996	\$ 1,350,000	\$ 1,143,211	12/2003	7.5000	\$ 89,177	1	
2												2	
3												3	
4												4	
5	AMCORE BANK		X	VEHICLES	\$624.50	1/2001	30,000	19,409	1/2006	9.0000	422	5	
	Working Capital												
6	FIRST IL NATIONAL BANK		X	WORKING CAPITAL	\$7,644.00			270,338		VARIABLE	16,712	6	
7	CORPORATE ALLOCATION	X		WORKING CAPITAL		6/2000	25,000	21,590	7/2010	9.0000	2,064	7	
8	OSO PARTNERS	X		WORKING CAPITAL	\$1,636.00	12/1996	167,700	121,903	12/2003	7.5000	10,532	8	
9	TOTAL Facility Related				\$21,495.50		\$ 1,572,700	\$ 1,576,451				\$ 118,907	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$				\$	14
15	TOTALS (line 9+line14)						\$ 1,572,700	\$ 1,576,451				\$ 118,907	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **PLEASANT VIEW**# **0042416** Report Period Beginning: **01-01-02** Ending: **12-31-02****12-31-02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report	\$	37,164	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	27,896	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(9,268)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	39,706	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$	30,438	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997 27,242 8			
		1998 26,479 9			
		1999 25,259 10			
		2000 26,195 11			
		2001 27,896 12			
			FOR OHF USE ONLY		
			13	FROM R. E. TAX STATEMENT FOR 2001 \$	13
			14	PLUS APPEAL COST FROM LINE 5 \$	14
			15	LESS REFUND FROM LINE 6 \$	15
			16	AMOUNT TO USE FOR RATE CALCULATION\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PLEASANT VIEW COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0042416

CONTACT PERSON REGARDING THIS REPORT ALAN GAPINSKI

TELEPHONE 815-778-3610 FAX #: 815-778-4503

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>00026326</u>	<u>PT NW SEC 17 TWP 21</u>	\$ <u>27,895.56</u>	\$ <u>27,895.56</u>
2. _____	<u>RNG 5 MF 10831-96</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>27,895.56</u>	\$ <u>27,895.56</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number PLEASANT VIEW

0042416 Report Period Beginning:

01-01-02 Ending:

12-31-02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,743 B. General Construction Type: Exterior BRICK Frame METAL Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization ☐ (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY GROUNDS		1996	\$ 50,000	1
2	ADDITIONAL GROUND		2002	82,500	2
3	TOTALS			\$ 132,500	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1996	1974	\$ 1,200,000	\$ 30,768	39	\$ 30,768		\$ 184,608	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		BOOSTER HEATER		1997	1,582	79	20	79		475	9
10		GARAGE/STORAGE		1997	1,670	84	20	84		501	10
11		BUILT IN WHIRLPOOL BATHING SYSTEM		1997	22,217	2,222	10	2,222		12,626	11
12		CIRCULATING PUMP		1997	1,353	135	10	135		1,285	12
13		FLOOR TILE		1997	1,430	95	15	95		548	13
14		REMODEL OFFICE		1997	8,092	809	10	809		4,451	14
15		FURNACES		1997	16,130	1,075	15	1,075		6,094	15
16		ROOM SIGNAGE		1997	1,666	167	10	167		916	16
17		PAINTING		1997	12,962	1,852	7	1,852		10,184	17
18		LOCKS & PLATE FLAQUES		1997	820	82	10	82		451	18
19		WINDOW TREATMENTS		1997	772	77	5	77		772	19
20		WINDOW TREATMENTS		1997	5,228	523	10	523		2,875	20
21		DOOR ALARM SYSTEM		1997	12,550	1,255	10	1,255		6,903	21
22		LANDSCAPING		1997	13,055	1,306	10	1,306		7,181	22
23		SEAL PARKING LOT		1997	2,926	293	5	293		2,926	23
24		OFFICE REMODELING (ADDT)		1998	6,367	910	7	910		4,472	24
25		BEAUTY SHOP REMODELING		1998	6,844	342	20	342		1,625	25
26		AIR CONDITIONING/HEATING UNITS		1998	6,332	422	15	422		1,759	26
27		SPRINKLER SYSTEM		1999	10,944	730	15	730		2,858	27
28		POLYVINYL FENCING		1999	2,133	142	15	142		509	28
29		GAZEBO		1999	7,383	492	15	492		1,723	29
30		REMODEL DINING ROOM		1999	20,459	1,023	20	1,023		3,154	30
31		INSTALL LIGHTS & CEILING FANS (NURSING STATION)		2000	989	49	20	49		144	31
32		65 GALLON WATER HEATER		2000	4,696	470	10	470		1,174	32
33		PLANTER INSTALLATION		2000	3,280	328	10	328		820	33
34		KITCHEN REMODELING		2001	13,860	924	15	924		1,848	34
35		FURNISH & INSTALL AWNING		2001	2,504	250	10	250		376	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	CHANGE A/C COMPRESSOR	2001	\$ 2,268	\$ 227	10	\$ 227		\$ 340	37
38	REMODEL LAUNDRY ROOM	2001	4,714	121	39	121		151	38
39	HEAT TAPE GUTTERS	2001	1,603	160	10	160		241	39
40	CEILING TILE, LIGHTS & INSTALLATION	2002	13,327	888	15	888		888	40
41	LAUNDRY ROOM FLOOR TILE	2002	1,125	75	15	75		75	41
42	COMMERCIAL DISPOSAL	2002	951	47	10	47		47	42
43	LAUNDRY ROOM A/C	2002	3,086	154	10	154		154	43
44	REPLACE ROOF	2002	47,430	593	20	593		593	44
45	SHUTTERS	2002	852	5	15	5		5	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,463,600	\$ 49,174		\$ 49,174		\$ 265,752	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 413,888	\$ 44,360	\$ 57,214	\$ 12,854	VARIOUS	\$ 258,568	71
72	Current Year Purchases	22,014	1,989	1,989		VARIOUS	1,989	72
73	Fully Depreciated Assets							73
74	HOME OFFICE ALLOCATION		746	746				74
75	TOTALS	\$ 435,902	\$ 47,095	\$ 59,949	\$ 12,854		\$ 260,557	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HOME OFFICE ALLOCATION			\$	\$ 1,752	\$ 1,752		5		76
77										77
78										78
79										79
80	TOTALS			\$	\$ 1,752	\$ 1,752				80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,032,002	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 98,021	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 110,875	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,854	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 526,309	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$		91

G. Construction-in-Progres

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column f

A. Building and Fixed Equipment (See instructions.)

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES ☐ NO

14.	<u>12/31/05</u>	\$ <u>171,698</u>
-----	-----------------	-------------------

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input checked="" type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE <u>96</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input checked="" type="checkbox"/> HOURS PER AIDE <u>48</u>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$		\$
2	Books and Supplies			330	330
3	Classroom Wages (a)	5,671	8,575		14,246
4	Clinical Wages (b)		4,287		4,287
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payments			5,005	5,005
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 5,671	\$ 12,862	\$ 5,335	\$ 23,868
10	SUM OF line 9, col. 1 and 2 (e)	\$ 18,533			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefit.
 (c) For in-house training programs only. Do not include fringe benefit.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities:

\$ NONE

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	10
2. From other facilities (f)	
TOTAL TRAINED	21

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (73)	\$ 211,820	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 24565/67299)	379,738	762,734	3
4	Supply Inventory (priced at COST)	24,409	63,997	4
5	Short-Term Investments			5
6	Prepaid Insurance	14,715	25,311	6
7	Other Prepaid Expenses	4,151	13,373	7
8	Accounts Receivable (owners or related parties)	(195,232)		8
9	Other(specify): OTHER RECEIVABLES		11,911	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 227,708	\$ 1,089,146	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	82,500	82,500	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	263,600	286,008	15
16	Equipment, at Historical Cost	201,303	881,028	16
17	Accumulated Depreciation (book methods)	(168,023)	(688,517)	17
18	Deferred Charges	101,106	101,106	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEFERRED MAINT. (NET)	629	629	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 481,115	\$ 662,754	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 708,823	\$ 1,751,900	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 179,681	\$ 610,699	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	67,000	67,000	29
30	Accrued Salaries Payable	71,418	141,140	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,747	37,780	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,707	81,253	32
33	Accrued Interest Payable	1,698	3,256	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 370,251	\$ 941,128	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	325,239	486,995	39
40	Mortgage Payable		197,389	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>DUE TO OSO PARTNERS</u>	207,597	207,597	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 532,836	\$ 891,981	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 903,087	\$ 1,833,109	46
47	TOTAL EQUITY(page 18, line 24)	\$ (194,264)	\$ (81,209)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 708,823	\$ 1,751,900	48

*(See instructions.)

Facility Name & ID Number PLEASANT VIEW

0042416

Report Period Beginning: 01-01-02

Ending: 12-31-02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached**Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses.**

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,352,358	1
2	Discounts and Allowances for all Levels	(6,500)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,345,858	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,880	6
7	Oxygen	7,162	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 16,042	8
C. Other Operating Revenue			
9	Payments for Education	1,000	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement	9,887	11
12	Gift and Coffee Shop	195	12
13	Barber and Beauty Care	9,443	13
14	Non-Patient Meals	3,330	14
15	Telephone, Television and Radio	4,029	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 27,884	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	1,794	28
28a	EMPLOYEES AT OTHER FACILITIES/MISC	16,684	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,478	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,408,262	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	574,584	31
32	Health Care	996,030	32
33	General Administration	454,073	33
B. Capital Expense			
34	Ownership	274,971	34
C. Ancillary Expense			
35	Special Cost Centers	9,297	35
36	Provider Participation Fee	40,515	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,349,470	40
41	Income before Income Taxes (line 30 minus line 40)**	58,792	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 58,792	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (253,056)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (253,056)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	58,792	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 58,792	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (194,264)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number PLEASANT VIEW

0042416

Report Period Beginning: 01-01-02

Ending:

12-31-02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,016	2,072	\$ 45,208	\$ 21.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,874	11,019	188,941	17.15	3
4	Licensed Practical Nurses	7,398	7,786	126,898	16.30	4
5	Nurse Aides & Orderlies	42,416	45,873	401,038	8.74	5
6	Nurse Aide Trainees	2,281	2,281	18,533	8.12	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,752	1,944	23,037	11.85	8
9	Activity Director	1,924	2,080	28,164	13.54	9
10	Activity Assistants	1,976	2,100	24,891	11.85	10
11	Social Service Worker	4,094	4,494	53,631	11.93	11
12	Dietician					12
13	Food Service Supervisor	1,900	2,112	23,587	11.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,108	19,313	138,406	7.17	15
16	Dishwashers					16
17	Maintenance Worker	5,287	5,803	59,021	10.17	17
18	Housekeepers	4,406	4,686	36,707	7.83	18
19	Laundry	6,039	6,619	43,052	6.50	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,899	2,086	23,383	11.21	23
24	Clerical	1,983	2,063	16,397	7.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,327	1,477	14,840	10.05	31
32	Other Health Care(specify)					32
33	Other(specify) BARBER/BEAUTY			7,514		33
34	TOTAL (lines 1 - 33)	114,680	123,808	\$ 1,273,248 *	\$ 10.28	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	124	\$ 6,178	1,3	35
36	Medical Director	30	3,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	18	888	10,3	39
40	Physical Therapy Consultant	47	2,333	10a,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	960	11,3	44
45	Social Service Consultant				45
46	Other(specify) LAB	1	55	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	244	\$ 13,414		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	25	737	10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	25	\$ 737		53

A. Administrative Salaries:		Ownership	D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$ 25,419	IDPH License Fee	\$	
				Unemployment Compensation Insurance	8,254	Advertising: Employee Recruitment	1,149	
				FICA Taxes	94,348	Health Care Worker Background Check		
				Employee Health Insurance	36,384	(Indicate # of checks performed 36)	250	
				Employee Meals		DUES & SUBSCRIPTIONS	5,148	
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING	11,107	
				DISABILITY INSURANCE	14,486	PRINTING	1,204	
				LIFE INSURANCE	3,128	HOME OFFICE ALLOCATION	307	
TOTAL (agree to Schedule V, line 17, col. 1)				401 K	5,596			
(List each licensed administrator separately.)			\$	PHYSICALS	35			
B. Administrative - Other				EMPLOYEE RECOGNITION EVENTS	4,540	Less: Public Relations Expense	()	
Description		Amount				Non-allowable advertising	(11,107)	
AMERICAN HEALTH ENTERPRISES		\$ 117,194		HOME OFFICE ALLOCATION	10,183	Yellow page advertising	(0)	
				TOTAL (agree to Schedule V,	\$ 202,373	TOTAL (agree to Sch. V,		
				line 22, col.8)		line 20, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 117,194	E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				to Owners or Employees				
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type	Amount				\$	Out-of-State Travel	\$
		\$						
ACHIEVE	SOFTWARE MAINTENANCE	3,662					In-State Travel	
CREATIVE SOLUTIONS	MEDICAL RECORDS	3,655					LISTING ATTACHED	5,460
MIDWEST AUTOMATED TIME	TIMECLOCK SOFTWARE	525					HOME OFFICE ALLOCATION	153
JOHN PYSE	COMPUTER CONSULTANT	4,064						
INTERNET SERVICES	INTERNET ACCESS	260					Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 12,166				line 24, col. 8)	\$ 5,613

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year									13
					6 FY1999	7 FY2000	8 FY2001	9 FY2002	10 FY2003	11 FY2004	12 FY2005	13 FY2006	14 FY2007	
1	PAINTING	JUNE 2001	\$ 899	5	\$	\$	\$ 90	\$ 180	\$	\$	\$	\$	\$	
2														
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20	TOTALS		\$ 899		\$	\$	\$ 90	\$ 180	\$	\$	\$	\$	\$	

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of service performed been attached to this cost report N/A
Attach invoices and a summary of services for all architect and appraisal fee